ics costs were 167.4 times higher than typical antipsychotic costs. AP mean monthly costs per person varied with the type of association between antipsychotics: typical-atypical associations costs were U$257.5± U$228.5, while mean costs between two typical antipsychotics were U$4.36 ± U$4.02. Polypharmacy added U$300.00 dolars per person per month to direct costs of health care (excluding accomodation). For each additional antipsychotic associated, it was observed an additional montlhy costs per person of U$87.5 in the total costs of health care package (health services, treatment and accomodation). **CONCLUSIONS:** AP added substantial costs and risks to treatment and to health care costs and quality. This should be taken in account in resource allocation in public policies, especially in low-resources settings.

PMH7

MODELIZACIÓN ECONÓMICA DEL GENOTIPADO DEL CITOCROMO P450 CON EL TEST BRAINCHIP EN EL TRATAMIENTO DE LA DEPRESIÓN MAYOR

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OBJECTIVOS: BrainChip es un test genético que predice la respuesta al tratamiento farmacológico de la depresión mayor (DM) determinando los polimorfismos de las isoenzimas CYP450. El objetivo ha sido valorar la eficienciade la incorporación del test BrainChip previa a la prescripción farmacológica en DM tras fallo en primera línea. **METODOLOGÍAS:** Se desarrolló un modelo de Markov de ciclos bimensuales para cada fármacode una cohorte hipotética depacientes adultos con DM tras fallo en primera línea. La cohorte se adecuó a la distribución del mercado actual y a su modificación tras incorporar BrainChip. Los datos de eficacia (no respuesta, respuesta y remisión) provienen de revisiones de la literatura y el uso de recursos y costes fue adaptado para el análisis inicial a España. Se analizaron los resultados en un horizonte temporal de 1, 3, 5, 7 y 10 años desde la perspectiva del sistema sanitario aplicando un descuento del 3% sobre los efectos y los costes (euros 2011). **RESULTADOS:** BrainChip mejora la remisión entre un 9,5%-11,7% y la respuesta entre 5,5%-10,2%, alcanzando a los 10 años una respuesta del 72%. Los pacientes con DM mejoran la calidad de vida con BrainChip entre 0,04 y 0,25 años de vida ajustados por calidad. El coste de Brainchip se compensa a los 2 años resultando siempre coste-efectivo a corto plazo y dominante a partir del tercer año, mostrando ahorros de 1399€/paciente tras 10 años. **CONCLUSIONES:** BrainChip en DM es dominante, permite prescribir los tratamientos con menos riesgos y costes y más eficacia. El modelo desarrollado permitiría la adaptación del análisis a cualquier país de Latinoamérica utilizando datos de costos locales.

PMH8

COST EFFECTIVENESS OF PALIPERIDONE PALMITATE VERSUS RISPERIDONE LONG-ACTING INJECTABLE, QUETIAPINE AND OLANZAPINE FOR THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA IN COLOMBIA

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OBJECTIVES: Schizophrenia is a chronic disorder that requires long-term treatment with antipsychotic medication to minimize relapse and provide clinical benefit to patients. For patients with schizophrenia, non-adherence to medication is a risk factor for relapse and re-hospitalization. Long-acting Injectable (LAI) formulations of atypical antipsychotics provide constant medication delivery and the potential for improved adherence. The objective of this study is to assess the cost-effectiveness of paliperidone palmitate (PP) versus risperidone long acting injectable (RLAI), olanzapine (OP) and quetiapine (QP). **METHODS:** A Markov decision analytic model was developed to simulate multi-episode patients transitioning through different states on monthly basis over a 5 year time horizon from the perspective of the Colombian Health System. Probability of relapse, level of adherence, side effects, utilities and treatment discontinuation were derived from scientific literature. Only direct costs were considered as medications, laboratory tests, relapses and adverse events by using national tariffs and prices from Ministry of Health medication database. Outcomes were measured as relapses rate and Quality Adjusted Life Years (QALY). Discount rate 3%, exchange rate (1 USD = 1,794 COP) and threshold considered 3xPIB per capita (USD 20,066 / QALY). **RESULTS:** *Total costs (USD):* PP (13,338), RLAI (12,635), OP (11,481) and QP (13,247). *Hospitalization relapses costs (USD):* PP (3,276), RLAI (3,341), OP (4,881) and QP (6,840). *QALY:* PP (3.09), RLAI (3.00), OP (2.93) and QP (2.87). *Relapses rate:* PP (1.35), RLAI (1.38), OP (2.01) and QP (2.81). *Incremental Cost Utility Ratios (ICUR: USD / QALY):* PP vs. RLAI (4,517), PP vs. OP (6,713) and PP vs. QP (230). **CONCLUSIONS:** Considering a willingness to pay of USD 20,066 per QALY, the incremental cost of PP versus other alternatives could be compensated by its incremental benefits in terms of relapses avoided and QALY gained. From Health Care Provider perspective, PP demonstrates savings in terms of less hospital setting relapsing costs.

PMH9

THE COST-EFFECTIVENESS AND COST-UTILITY OF PALIPERIDONE PALMITATE IN THE TREATMENT OF SCHIZOPHRENIA IN GUATEMALA

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OBJECTIVES: To compare from the Guatemaltecan third payer perspective the cost-effectiveness of paliperidone palmitate with oral quetiapine. **METHODS:** A Markov model was developed to assess the cost-effectiveness and the cost-utility of treatments available for schizophrenia in Guatemala. The model was adjusted to reflect the compliance of the patient and the real world effectiveness of both treatments. A 10 year time horizon was used. All direct medical costs relevant for the third payer were included. Four types of side effects were considered in the model: extrapyramidal symptoms, weight gain, diabetes and tardive dyskinesia. Deterministic and probabilistic sensitivity analyses were performed. **RESULTS:** Effectiveness outcomes were reported both in QALYs and relapses avoided. The costs were reported in the local currency Quetzales and all cost and outcomes were discounted at 5% per year. Paliperidone palmitate dominated oral quetiapine by being less expensive (14% less) and more effective (44% less relapses and 20% more QALYs). The sensitive analyses confirmed the robustness of the results. **CONCLUSIONS:** Paliperidone palmitate appeared to be a cost-saving treatment option in comparison with oral quetiapine for patients with schizophrenia in Guatemala. The model reflected a better compliance with paliperidone palmitate that is related to less relapses, a better quality of life and reduced hospitalization costs.

MENTAL HEALTH – Patient-Reported Outcomes & Patient Preference Studies

PMH10

NEEDS ASSESSMENT OF PATIENTS TREATED IN COMMUNITY PSYCHOSOCIAL CENTERS IN SÃO PAULO, BRAZIL

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OBJECTIVES: To describe the needs of patients treated at community psychosocial centers in Sao Paulo, Brazil. **METHODS:** Cross-sectional study with 373 patients who were attending psychosocial care activities at least three times per week in community psychosocial centers, during 2007-2008. Needs were assessed using the "Camberwell Assessment of Need" (CAN). Psychotic symptoms were assessed using the "Positive and Negative Symptom Schedule" (PANSS). **RESULTS:** Mean age of patients was 40.0 years (standard deviation, SD = 12.6 years); 57.6% were male, 57.9% had fundamental education, 40.5% have schizophrenia, 15.9% have worked during last 12 months and 14.7% were living alone. Median time attending in community psychosocial centers was two years (range of 15 days to 30 years) and mean number of weekly therapeutic activities was 3.6 (SD = 2.3). The mean score for the total number of needs was 7.1 (SD = 2.8), with a range of 0 to 15 (maximum = 22). Basic needs were reported by 38 (10.2%) patients; at least one social need was reported by 90.9%. At least one functioning need was reported by 94.4% patients; 85.5% have at least one health need; 86.3% have at least one service need. Women showed higher number of needs than men ($p = 0.02$) and educational until fundamental level was also associated with more needs ($p = 0.02$). We did not observe associations between weekly activities, unemployment, age, diagnosis and number of needs. Patients with higher PANSS scores showed more needs ($p < 0.001$). **CONCLUSIONS:** We observed higher number of needs than in studies conducted in Europe, in all conceptual domains assessed by CAN. Many patients showed needs related to health and services, despite the time that they were attending in community psychosocial centers. Patients' needs should take in account in order to improve the quality of care offered in mental health services.

MENTAL HEALTH – Health Care Use & Policy Studies

PMH11

CLINICAL PRACTICE GUIDELINE MAJOR DEPRESSIVE DISORDER FOR GENERAL PRACTITIONERS

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OBJECTIVES: To develop the clinical practice guideline major depressive disorder for general practitioners in primary and secondary health care setting included the diagnosis, differential diagnosis, severity classification and medical treatments. **METHODS:** A list of 13 key elements of a CPG development process were developed that consisted of 1) setting the review teams; 2) determining the problems; 3) determining health outcomes;4) evidence based literature review; 5) meeting to draft the CPG; 6) formulating draft of CPG; 7) apprising the content of CPG by experts; 8) trail phase; 9) evaluating for trail phase; 10) developing the curricular for CPG training; 11) preparing for CPG training; 12) evaluating; and 13) improving the CPG related with evaluated results. **RESULTS:** There were 3 main processes in clinical practice guideline major depressive disorder for general practitioners in primary and secondary health care setting (CPG-MDD-GP) which were 1) Assessment of major depressive disorder (clinical assessment using 9Q screening tool and DSM-TR diagnostic criteria, differential diagnosis, diagnosis for major depressive disorder and coding of diagnosis); 2) Management of major depressive disorder; and 3) Management of hospitalized patients. General practitioners were satisfied with the CPG-MDD-GP in trial phase. A total of 416 general practitioners in all provinces were trained to use the CPG-MDD-GP then they would be followed and evaluated. Psychiatrists in psychiatric hospitals/ institutes would be available for consultation from the general practitioners. **CONCLUSIONS:** The CPG-MDD-GP should be distributed to all general practitioners in primary and secondary health care setting. Next step, it would be useful for developing the CPG for MDD in the tertiary health care setting.

PMH12

CONTRIBUTION OF LATIN AMERICA TO MENTAL HEALTH IN PREGNANCY

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OBJECTIVES: To identify and describe published articles dealing with issues of mental health in pregnancy from Latin American counties **METHODS:** Medline, Embase and LILACS databases were searched for published studies originating from Latin America regarding mental health issues in pregnancy. Search terms included the names of all countries in the United States Census Bureau International Database + mental health + pregnancy. We included all research and review articles dealing with pregnancy and/or lactation, epidemiology of mental disorders, prevention or treatment of mental disorders, outcomes assessment, and counseling/drug information dissemination. Excluded were papers dealing exlusively with postpartum depression, HIV transmission, induction of abortion, in vitro fertilization, contraception or the use of alcohol or drugs of abuse. Data were analyzed descriptively. **RESULTS:** The search identified 701 studies; 110 (16%) met the criteria. The earliest was published in 1984 and the contribution has increased exponentially [Y=-1E-125*exp(0.1452X), where X is the year; R-squared=0.97). The majority (n=80; 73%) consisted of original research and the other 27% were reviews (23 overviews, 3 systematic reviews/meta-analyses, 4 other). Most frequent topics were depression (37%) as well as mixed anxiety/depression (6%), mental health during pregnancy (32%;), psychotropic drug use in pregnancy (13%), suicidality (6%), and quality of life (1%). By country, 58 (53%) were produced by Brazil, followed by Mexico (n=18, 17%), Chile (n=10, 9%), Colombia